CALIFORNIA DEPARTMENT OF
Mental Health

AB 328 REALIGNMENT DATA

Data Gathered for the Legislature as Required by

Assembly Bill 328 (Salinas)
Chapter 367, Statutes of 2001

Assembly Bill 2044 (Salinas)
Chapter 648, Statutes of 2002

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Data on Current Status of County Mental Health Programs

Pursuant to Chapter 367, Statutes of 2001, Salinas

Introduction

In 1991, a major change occurred in the funding of human service programs in the State of California. The Health and Welfare Realignment Program transferred financial responsibility for most of the mental health and public health programs, and some of the social service programs, from the state to local governments and provided counties with a dedicated revenue source to pay for these changes. Eleven years later, mental health programs throughout the state have benefited from this dedicated funding source and increased flexibility to develop programs, but several county mental health programs[1] are experiencing severe funding shortfalls and many more are projecting shortfalls in the near future. There are increasing fears that these shortages will require reductions in the number of people served and the levels of service. Because of such concerns, the Legislature enacted and the Governor signed AB 328 in 2001. (Statutory text is included as Appendix A.) This legislation directs the state Department of Mental Health (DMH) in cooperation with the California Mental Health Directors Association (CMHDA) and other relevant parties, to submit data on the current status of county mental health programs that includes the following:

- The current structure and status of the financing of mental health services established under realignment.
- Changes in the current service delivery system of mental health programs that have occurred since the enactment of realignment.
- Trends in the financial status and service delivery systems within county mental health programs.

This summary provides this information, including a careful analysis of data and trends relating to mental health services provided, expenditures, and revenues (with an emphasis on realignment funding.)

The Appendices to this report contain some of the background material and specific information used to compile the summary statistics presented in this main body of the report. Additional detailed reports showing county specific information across several years are posted on the department's web site,

[1] As used in this report, the references to county mental health programs include the two city mental health programs as well.

www.dmh.ca.gov. (Appendix D lists the web site data that is particularly relevant to this report.)

Methodology

As directed in the legislation, DMH worked closely with CMHDA in preparing this report. Specifically, meetings were held with the Financial Services Committee whose members provided technical assistance and specific information regarding county data practices and procedures. The CMHDA Governing Board surveyed several counties and provided technical assistance regarding critical issues facing county mental health departments.

Data for this report were developed from multiple sources using a time span of 10 years. A description of each database and the years it was in effect are included in Appendix C. There are many limitations to the data, especially when looking at a specific service type within a specific county. Although it is accurate to the best of our knowledge and ability, variations in reporting across providers and counties and within a county over time continue to exist. To help address these concerns, the data were distributed to county mental health directors for review and comments, as well as posted on the Department of Mental Health's public website. Very few comments were received regarding changes to the data or inaccuracies in the data, so it was used as reported with some exceptions, which are noted in the data source Appendix C. In addition, there were several other data issues that are also discussed there. These limitations need to be kept in mind when trying to draw conclusions because the data trends could be a result of a reporting error and not a mental health system effect.

In addition to publicizing the data, DMH also provided two stakeholder forums where information about the development of the report was shared and discussed, and input was obtained from those attending. Input from stakeholders has played a significant role in shaping this report, and stakeholder comments are incorporated throughout the document.

Financing of Mental Health Services

Prior to Realignment

In 1957, California passed the Short-Doyle Act, which was administered by the DMH. This act provided matching state funds to counties and cities for delivery of mental health services to their residents. The matching ratio increased from 50% state funds-50% county funds to 75% state funds-25% county funds, then eventually to 90% state funds-10% county funds in 1969 when it became mandatory for counties with populations over 100,000 to provide mental health services. In Fiscal Year (FY) 1973-74, it became mandatory for all counties to have a mental health program.

Realignment

Description

In 1991, California faced a $14.3 billion budget deficit. Initially, responding to the then Governor's proposal to transfer authority over some mental health and health programs to counties, the Legislature considered a number of options to simultaneously reduce the state's budget shortfall and improve the workings of state-county programs. (For more detail on Realignment funding, see Appendix D.6.)

In addition to dealing with the fiscal crisis, there were a number of concerns about mental health programs and services in California.

- *Lack of Stability in Mental Health Funding*. Prior to 1991, state funding for county mental health services was subject to annual legislative appropriation, which varied significantly from year to year, depending on the state's financial condition.

- *Constraints on Program Flexibility*. The lack of local flexibility due to the extent of categorical funding and resources dedicated to inpatient programs was also a concern at the time realignment was considered.

- *Lack of System Accountability*. Finally, the enactment of realignment was intended to provide more effective state supervision and oversight of local mental health programs.

The Legislature responded to all of these issues by enacting the Bronzan-McCorquodale Act, (Chapter 89, Statutes of 1991,) referred to as "Realignment." Realignment was a major change in the state and local relationship. In addition to the governance issues highlighted above, the *Master Plan* which was developed with extensive involvement of stakeholders in response to Chapter 1313, Statutes of 1989 (AB 904, Farr) provided many of the philosophical and contextual underpinnings for the population and services priorities included in this legislation.

Realignment represented a new partnership between the State and the counties governing the provision of services. The core principle under Realignment was to provide expanded discretion and flexibility to counties to expend State funding. It shifted program and funding responsibilities from the state to counties, adjusted cost-sharing ratios, and provided counties a dedicated revenue stream to pay for these changes in the areas of mental health, social and health services. State oversight was to be increasingly focused on outcome and performance based measures. The distribution formula allowed for additional growth funding for those counties who historically were under "equity."

Realignment transferred the amounts associated with pre-realignment categorical programs, general community mental health funding, and state hospital civil commitment funding, and Institutions for Mental Disease funding. (Included on the DMH web site is the FY 1990-91 funding sources used to calculate the resource base for use in FY 1991-92.)

The realigned funds were broken into the CMHDA regions as shown in Table 1, below. (Appendix C specifies the counties in the CMHDA regions.)

Table 1
FY 1990-91 Mental Health Funding Sources for Realignment
By CMHDA Region

CMHDA Region	Amount	Percent
Bay Area	$202,221,830	27.0%
Central	102,100,979	13.6%
Southern	179,628,590	24.0%
Superior	26,969,757	3.6%
Los Angeles	238,717,844	31.8%
Total	$749,639,000	100.0%

In addition to the realigned funding sources, there were approximately an additional $525 million in other funding sources in FY 1990-91 that were used to provide mental health services either through county mental health programs or Fee-for-Service/Medi-Cal providers reimbursed through the state Department of Health Services (DHS). (These funding sources and amounts are also detailed in Appendix B.)

Thus, total mental health revenues in FY 1990-91 were almost $1.3 billion, with the realigned revenues accounting for almost 60 percent of the total mental health program.

Funding Sources for Realignment

In order to fund the program transfers and shifts in cost-sharing ratios, the Legislature enacted two tax increases in 1991, with the increased revenues deposited into a state Local Revenue Fund and dedicated to funding the realigned programs. Each county created three program accounts, one each for mental health, social services, and health. Through a series of accounts and sub-accounts at the state level, counties receive deposits into their three accounts for spending on programs in the respective policy areas. The basic

formula, which determines the amount to each county and each sub-account, was included in the statute.

- *Sales Tax***.** In 1991, the statewide sales tax rate was increased by a half-cent. The half-cent sales tax generated $1.3 billion in 1991-92 and is expected to generate $2.4 billion in FY 2001-02.

- *Vehicle License Fee***.** The VLF, an annual fee on the ownership of registered vehicles in California, is based on the estimated current value of the vehicle. In 1991, the depreciation schedule upon which the value of vehicles is calculated was changed so that vehicles were assumed to hold more of their value over time. At the time of the tax increase, realignment was dedicated 24.33 percent of total VLF revenues--the expected revenue increase from the change in the depreciation schedule.

  In recent years, the Legislature has reduced the effective VLF tax rate. As of 2001, the effective rate is 67.5 percent lower than it was in 1998. The state's General Fund, through a continuous appropriation to local governments outside of the annual budget process, replaces the dollars that were previously paid by vehicle owners. In other words, realignment continues to receive the same amount of dollars from VLF sources as under prior law. The VLF allocations to realignment have grown from $680 million in FY 1991-92 to an expected $1.2 billion in 2001-02.

- *The VLF Collections*. In 1993, the authority to collect delinquent VLF revenues was transferred from the Department of Motor Vehicles (DMV) to the Franchise Tax Board (FTB) in order to increase the effectiveness of delinquent collections. The first $14 million collected annually by the FTB is allocated to counties' mental health accounts as part of realignment. The State DMH in consultation with CMHDA develops the distribution schedule.

Realignment Impact

At the state level, realignment was designed to stabilize funding for the mental health system. Many factors have caused increases and decreases to mental health funding over the past decade. However, the structural change in revenue sources that provided dedicated funding for mental health services and the elimination of competition with entitlement programs for state general funds (SGF) has improved the stability of funding.

At the county level, realignment reorganized authority and control over resources in the mental health system, creating a single system of care at the county level and giving counties more control over their revenues. Realignment provided counties with additional flexibility regarding the use of mental health funds for

those receiving services from the county. These include services provided through state hospitals, IMDs and community-based programs. Counties can now use funds that were dedicated to state hospitals and IMDs for other mental health services or contract for these beds as needed.

From a fiscal standpoint, realignment has generally provided counties with the following advantages**:**

- A stable and growing funding source for programs which has made a long-term investment in mental health infrastructure financially practical.
- Greater fiscal flexibility, discretion and control.
- The ability to streamline bureaucracy and reduce overhead costs.
- The ability to use funds to reduce high-cost restrictive placements, and to place clients appropriately.
- Financial incentives for counties to properly manage mental health resources, including the ability to "roll-over" funds from one year to the next, which enables long-term planning and multi-year funding of projects

At the same time, it is important to note that realignment funding was based upon the current funding going to each county at the time of implementation, and did not take into consideration the adequacy of funding prior to 1991.

Current Realignment Funding

Annually, realignment revenues are distributed to counties until each county receives funds equal to the previous year's total. Funds received above that amount are placed into a growth account. The distribution of growth funds is complex. However, it is a fixed amount annually and the first claim on the Sales Tax Growth Account goes to caseload-driven social service programs. Any remaining growth from the Sales Tax Account and all VLF growth are then distributed according to a formula developed in statute. Originally, the balance was distributed to "under-equity[2]" counties, in addition to their General Growth. The equity sub-account had a capped total amount, which has now been reached; thus that account has become dormant. All growth will now be distributed as General Growth to all of the counties. Largely because of caseload growth in child welfare/foster care and minimum wage increases in In-Home Supportive Services (IHSS), growth distributions to health and mental

[2] "Equity" is defined by Realignment as a county's percentage share of the statewide Realignment resource base in comparison to a combination of that jurisdiction's percentage share of the statewide population and the statewide poverty population (calculated as the sum of the above two percentages, divided by two). Those whose payments are a lower percentage than the population/poverty percentage are said to be "under-equity", which can be measured in dollars.

health have been reduced in recent years. That trend is expected to continue. Realignment funds allocated by the Controller are deposited into and expended from the Mental Health, Social Services, and Health Trust funds at the local level. Revenues deposited into these accounts are used to fund programs specified in realignment legislation.

Counties are permitted to transfer funds between the accounts to reflect local needs and priorities among realigned programs. There are specific requirements as to the percentages of funds that can be transferred (generally 10% annually) and counties must provide information about substantial changes in their allocations of money among the three trust funds and document that the change(s) were based on the most cost-effective use of available resources to maximize client outcomes.

Realignment provides the fiscal foundation for local public mental health programs in California. It provides the most flexibility to meet local needs within a statewide framework of services to individuals with serious mental illness or serious emotional disturbances. It represents the largest source of revenue for local mental health programs. In FY 90/91 realigned funds represented 60% of revenues, and currently represent approximately 40% of total mental health funding statewide.

Other Mental Health Program Funding Resources

Table 2 below shows the estimated sources of revenues for county mental health programs in FY 2000/01.

Table 2

Estimated County Mental Health Funding FY 2000-01	
Realignment (Sales Tax and Vehicle Licensing Fees)	$1,000,000,000
County Funds	150,000,000
State Funds	
Consolidation/Managed Care	180,000,000
EPSDT (Medi-Cal services for children)	150,000,000
Adult Systems of Care (AB 3777 and AB 34)	60,000,000
Special Education Pupils (AB 3632/Chapter 26.5)	100,000,000
Includes SB 90 claims	
Children's Systems of Care	40,000,000
CalWORKs	50,000,000
Federal Financial Participation (FFP)	
Federal Share of Medi-Cal	575,000,000
Federal Share of Healthy Families	5,000,000
Other Funds	
Grants	
SAMHSA (Federal)	40,000,000
PATH (Federal for Homeless Projects)	5,000,000
Other Grants	15,000,000
Patient Fees and Insurance	25,000,000
Medicare	40,000,000
TOTAL	$2,435,000,000

Impact of Medi-Cal on the Mental Health System since Realignment

The second largest revenue source for county mental health programs is Federal Medicaid dollars. Understanding the changes in California's Mental Health Medi-Cal program since Realignment and the interaction of Medi-Cal revenues with realignment are critical to analyzing the current structure and status of public mental health services in California.

In 1966, California passed legislation to implement the Medicaid program by establishing the California Medical Assistance Program in the Office of Health Care Services. Since that time, the program has become known as Medi-Cal,

and now includes many additional specialized programs. DHS is the single state agency that administers the program. The Medi-Cal program originally consisted of physical health care benefits with mental health treatment making up only a small part of the program. Mental health services were limited to treatment provided by physicians (psychiatrists), psychologists, hospitals, and nursing facilities, and were reimbursed through the Fee-For-Service Medi-Cal system (FFS/MC).

There was no federal funding of the county Short-Doyle mental health program until the early 1970's,when it was recognized these programs were treating many Medi-Cal beneficiaries. Short-Doyle/Medi-Cal (SD/MC) started as a pilot project in 1971, and counties were able to obtain federal funds to match their own funding to provide certain mental health services to Medi-Cal eligible individuals. The SD/MC program offered a broader range of mental health services than those provided by the original Medi-Cal program.

A Medicaid State Plan Amendment implemented in July of 1993, added services available under the Rehabilitation Option to the SD/MC scope of benefits and broadened the range of personnel who could provide services and the locations at which services could be delivered. This change is significant in analyzing the financial status of mental health programs because it enabled counties to greatly increase their claiming of federal Medicaid funds.

The SD/MC program now includes inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, medication support, and crisis intervention.

The two separate Medi-Cal mental health systems, FFS/MC (the original Medi-Cal mental health system) and SD/MC, continued as separate programs until Medi-Cal mental health consolidation began in January 1995. From 1995 through 1998, there was a major shift in county obligations within the Medi-Cal Program. In order to provide counties more flexibility in the use of state funding and to enable more integrated and coordinated care, the State developed a plan to consolidate the two Medi-Cal funding streams for mental health services. This strategy was intended to allow a prudent purchaser of services to obtain maximum benefit for its expenditures and would allow for increased access to specialty mental health services within the same level of funding. Since research demonstrated that a single integrated system of care is critical for successful treatment of persistent mental illness and emotional disturbance and that the needs of persons with mental illness do not always receive adequate attention in an all-inclusive health care managed care system, the decision was made to "carve out" specialty mental health services from the rest of Medi-Cal managed care. County mental health departments were given the "first right of refusal" in choosing to be the mental health plan (MHP) for the county. All but two counties in California chose to become the MHP for their beneficiaries although there are

provisions to choose another entity to be the MHP if a county chooses not to assume that role. Those two counties chose to partner with another county to be the MHP.

This program operates under a federal Freedom of Choice waiver originally approved in May 1995 and subsequently renewed through the fall of 2002. Under this waiver program, each MHP contracts with DMH to provide medically necessary specialty mental health services to the beneficiaries of the county and is governed by state regulations in Title 9, California Code of Regulations, Division 1, Chapter 11. Medi-Cal beneficiaries must receive Medi-Cal reimbursed specialty mental health services through the MHPs. A distinction is made between specialty mental health care (those services requiring the services of a specialist in mental health) and general mental health care needs (those needs that could be met by a general health care practitioner). General mental health care needs for Medi-Cal beneficiaries remain under the purview of DHS either through their managed care plans or through the FFS/MC system.

MHPs receive a fixed annual allocation of state general fund (SGF) based on what DHS would have incurred for psychiatric inpatient hospital services and psychiatrist and psychologist services absent consolidation. Under the Early and Periodic Screening, Diagnosis and Treatment benefit (EPSDT), MHPs receive uncapped SGF for services provided to full scope Medi-Cal beneficiaries under 21 for outpatient specialty mental health services above a baseline expenditure level. These funds, together with realignment funds may be used as the state Medicaid match for claiming federal matching funds. More detail about Medi-Cal funding and its impact on realignment is presented in the Revenue Analysis section.

Other State General Funds

Specific initiatives provide additional categorical SGF to county mental health programs. These are shown in the Table 2 above. Virtually all of the State funds including Managed Care and EPSDT are targeted toward certain populations and come with their own sets of requirements. Some have specific eligibility requirements to serve new clients (such as CalWORKs and Healthy Families) or to serve an existing target population with expanded services (such as Adult Systems of Care and Children's Systems of Care). In many cases, no growth is built into these programs, nor do they always cover all of the administrative costs involved. They also come with expectations of collaboration with other government programs and the costs associated with these collaborations. These factors put more pressure on mental health base funding.

Medicare

Medicare funding has always been very limited in coverage for mental illness and is not focused on either rehabilitation or case management. Recent federal

efforts at cost control have further reduced the public mental health system's capacity to use Medicare in non-hospital settings.

Grants, Patient Fees and Insurance

The remaining sources of funding make up less than 5% of mental health program funding. As with the SGF programs, grants come with specific requirements and are often time-limited or decrease in amount over time.

Mental Health Service Delivery System

Since 1991, there have been dramatic changes in mental health service delivery systems initiated by realignment, the Rehabilitation Option, EPSDT, Medi-Cal consolidation and the move toward managed care. Many categorical funding sources were removed at the inception of realignment and new ones have since been initiated. Counties now have the authority to make resource allocation decisions regarding mental health services based on their own assessments of programmatic effectiveness. This new flexibility has led to changes in treatment strategies, whereby more clients are served in community-based programs.

From a service delivery standpoint, these changes in the structure and financing of mental health systems have generally provided counties and consumers with the following advantages:

- The establishment of priority populations and guidelines, and an array of services which constitute a comprehensive system of care for individuals with mental illness, to be provided to the extent resources are available.

- Greater flexibility to use funds appropriately and to take advantage of growing evidence around best practices in serving individuals with serious mental illness and serious emotional disturbances.

- For consumers, an increase in access to the decision-makers in the community regarding mental health services and the opportunity to be involved in the long-term planning process.

- A shift in program emphasis toward looking at and beginning to assess client outcomes.

The next section of the report presents trends in the service delivery systems within county mental health programs. Included below are demographic data and trend data regarding persons served through county mental health programs, types of services provided, and expenditures associated with these persons and programs. Four data points (FYs 1990-91, 1993-94, 1996-97 and 1999-00) and data for each county are included in Appendices as cited or on the Department's web site as noted in Appendix D; summary statewide and regional data are included in the body of this report.

In determining the population at-risk of needing public mental health services, we have used figures representing the total number of individuals who are at or below 200% of poverty (which includes all Medi-Cal beneficiaries), since these are the people who would most likely not be able to afford private care and would need to be seen in the public system.[3] From FY 1990-91 to FY 1999-00, the at-risk population increased from approximately 9.2 million to a little over 10.4 million, an increase of about 13%. Population data by age, for regions and counties is included in Appendix D.1.

Clients Served

While the at-risk population was increasing 13% from FY 1990-91 to FY 1999-00, statewide totals of clients served through county mental health programs increased from 320,704 to 486,137, or a total of almost 52%. Table 3 compares the percentage of growth by region in the total at-risk population with the percentage growth in total clients served during this period, further broken down for Medi-Cal clients. This disparity between population growth and client growth is due to several factors, including increased usage of services, and new Medi-Cal and EPSDT mandates.

[3] While the Medi-Cal numbers are updated each year, the non-Medi-Cal population at or under 200% of poverty is only available based on 1990 census figures, so we have estimated that part of the at-risk population by applying the same percentage increase as occurred in the total population.

Table 3

Average Annual Percent Change in "At-Risk" Population[a/] and Clients Served

Region	"At-Risk" Population			Clients Served		
	1991 to 1994	1994 to 1997	1997 to 2000	1991 to 1994	1994 to 1997	1997 to 2000
All Services						
Bay Area	1.1%	1.4%	1.6%	-0.6%	0.7%	6.6%
Central	1.8%	1.4%	2.1%	2.5%	2.8%	8.2%
Los Angeles	1.0%	0.8%	1.1%	1.7%	2.0%	6.5%
Southern	1.7%	1.4%	2.2%	4.7%	4.5%	14.6%
Superior	1.2%	0.8%	1.8%	2.6%	4.9%	8.6%
Total-All Services	1.3%	1.2%	1.7%	2.1%	2.7%	9.5%
Medi-Cal Services						
Bay Area	7.8%	-0.2%	-3.1%	6.8%	5.5%	5.2%
Central	6.6%	1.1%	-2.2%	3.1%	5.5%	10.7%
Los Angeles	10.7%	-0.1%	1.4%	4.9%	7.9%	31.9%
Southern	11.0%	0.7%	-3.6%	8.6%	8.7%	17.8%
Superior	5.9%	2.4%	-2.6%	8.5%	8.2%	9.3%
Total-Medi-Cal Services	9.3%	0.4%	-1.5%	6.2%	7.0%	16.2%

a/ "At-Risk" population is estimated 200% of poverty population for All Services and Medi-Cal Beneficiaries for Medi-Cal Services.

Penetration rates[4] for all clients increased from 3.48% in FY 1990-91 to 4.66% in FY 1999-00. Penetration rates for Medi-Cal clients increased from 3.40% to 6.20% during the same period. There were wide variations by county and region, with some overall penetration rates increasing, while others decreased in this period. All regions experienced an increase in Medi-Cal penetration rates. Table 4 shows penetration rates by region and by age. Recent penetration rate data for indigent clients for Los Angeles is not available due to a reporting error, which requires further investigation.

[4] Penetration rate is determined by dividing the number of clients seen in a year by the average monthly Medi-Cal beneficiaries for that year

Table 4
Penetration Rates[a/]

Region	Total		Medi-Cal		Non-Medi-Cal	
	1990-91	1999-2000	1990-91	1999-2000	1990-91	1999-2000
All Ages						
Bay Area	6.02%	6.50%	4.98%	7.35%	6.98%	5.70%
Central	3.95%	5.02%	4.03%	6.00%	3.85%	4.38%
Los Angeles	2.23%	2.77%	2.07%	4.90%	2.35%	N/A
Southern	3.12%	5.27%	3.29%	7.07%	3.01%	4.02%
Superior	4.68%	6.69%	4.88%	8.78%	4.48%	4.89%
Total-All Ages	3.48%	4.66%	3.40%	6.20%	3.55%	N/A
Ages 0 to 17						
Bay Area	3.14%	5.22%	2.45%	5.05%	4.43%	5.48%
Central	2.05%	3.47%	2.08%	4.79%	1.99%	2.04%
Los Angeles	1.27%	1.80%	1.11%	3.74%	1.50%	N/A
Southern	1.80%	4.18%	1.55%	5.24%	2.11%	2.99%
Superior	2.22%	5.33%	2.22%	7.94%	2.23%	2.84%
Total-Ages 0 - 17	1.87%	3.45%	1.67%	4.65%	2.17%	N/A
All 18 & over						
Bay Area	7.42%	7.13%	7.00%	8.97%	7.70%	5.78%
Central	5.46%	6.25%	6.13%	7.24%	4.84%	5.73%
Los Angeles	2.82%	3.36%	3.10%	6.14%	2.67%	N/A
Southern	3.92%	5.93%	5.07%	8.98%	3.37%	4.41%
Superior	6.12%	7.48%	6.93%	9.32%	5.45%	6.05%
Total-All 18+	4.47%	5.40%	5.11%	7.70%	4.09%	N/A

a/ Excludes State Hospital services, inpatient services claimed through EDS, outreach services, and Medi-Cal Administrative Activities (MAA).

Table 5 below shows that the numbers of Medi-Cal clients served increased 131%, while numbers of indigent clients served decreased by approximately 8%. This resulted in a shift in the balance between Medi-Cal and indigent clients from 45% Medi-Cal and 55 % indigent in FY 1990-91 to 68% Medi-Cal and 32% indigent clients in FY 1999-00. This shift is probably due to several factors: following realignment, counties were mandated to serve the Medi-Cal population who meet medical necessity criteria, and counties were making an effort to assist clients in getting on Medi-Cal since this provided additional federal dollars. Looking at age groups, the total number of clients under 18 more than doubled during this period (109%), while adults over 18 increased by only about 37%.

Medi-Cal differences for the age groups are even more pronounced, with youth increasing by 247%, while Medi-Cal adults served increased by almost 93%.

Table 5
Number of Clients[a/]

Region	Fiscal Year			
	1990-91	1993-94	1996-97	1999-2000
All Services				
Ages 0 - 17	65,456	72,337	92,170	137,045
Ages 18+	255,248	268,988	277,789	349,092
Total – All Ages	320,704	341,325	369,959	486,137
Medi-Cal Services				
Ages 0 - 17	35,249	47,881	71,678	122,256
Ages 18+	108,421	124,076	139,252	209,116
Total – All Ages	143,670	171,957	210,930	331,372
Non-Medi-Cal Services[b/]				
Ages 0 - 17	30,207	24,736	21,799	33,848
Ages 18+	146,835	145,270	138,906	143,976
Total – All Ages	177,034	170,006	159,567	163,625

a/ Excludes state hospital services, inpatient hospital services claimed through EDS, outreach services, and Medi-Cal Administrative Activities (MAA).

b/ Total of all ages is the difference between all services and Medi-Cal services. However, Medi-Cal clients in some counties exceeded total clients due to underreporting to CDS/CSI. As a result, clients are not additive within the Non-Medi-Cal services category and the total clients does not equal Medi-Cal added to non-Medi-Cal.

In summary, the number of clients served increased at a more rapid rate than the potential service population, and this increase was largely in the Medi-Cal population and greater for youth than for adults. The large growth in Medi-Cal youth is at least in part a reflection of the expansion of EPSDT services, which have broader eligibility criteria and are fully funded by a combination of state and federal funds.

Services Provided

Tables 6 and 7 show Medi-Cal and non-Medi-Cal units of service statewide for each of the four data points, together with the percentage increase in service units during each of the time periods.

Table 6
Medi-Cal Units of Service[a/]

Statewide	Medi-Cal Units of Service				Ave. Annual Percent Change		
	1990-91	1993-94	1996-97	1999-2000	1991-94	1994-97	1997-2000
All Ages	2,479,338	4,131,559	6,460,025	9,580,029	18.6%	16.1%	14.0%
Ages 0 to 17	583,368	818,017	2,139,387	4,026,615	11.9%	37.8%	23.5%
All 18 and over	1,895,970	3,313,542	4,320,638	5,553,414	20.5%	9.2%	8.7%

a/ Excludes Medi-Cal Administrative Activities (MAA).

Table 7
Non-Medi-Cal Units of Service[a/]

Region	Non-Medi-Cal Units of Service				Ave. Annual Percent Change		
	1990-91	1993-94	1996-97	1999-2000	1991-94	1994-97	1997-2000
All Ages	6,704,686	6,441,410	4,572,543	5,542,280	-1.3%	-10.8%	6.6%
Ages 0 to 17	1,018,412	1,455,536	769,849	1,241,813	12.6%	-19.1%	17.3%
All 18 and over	5,686,281	4,985,874	3,822,700	4,483,342	-4.3%	-8.5%	5.5%

a/ Excludes outreach services.

Statewide, service units increased by 65% between FY 1990-91 and FY 1999-00, with a 286% increase in Medi-Cal units and a 21% decrease in non-Medi-Cal units. This pattern of service units mirrors the pattern of increasing Medi-Cal and decreasing indigent clients served by mental health programs. Region and county specific data by service and summarized by inpatient/outpatient is provided on the DMH web site (see Appendix D.11d – D.11f). There are large variations from year to year, and among counties and regions throughout the time period presented here. Further study would be needed to understand the variations, but for purposes of this report it is sufficient to note that there was a significant increase in the volume of services being provided to Medi-Cal clients, and this increase was greater for children (590%) than for adults (193%).

Another significant shift can be seen in the type of services being provided to clients. The proportion of the total funding for outpatient services increased from 40% in FY 90/91 to 73% in FY 99/00. More detail is in the following section on expenditures.

While inpatient units of service increased less than 3%, outpatient units increased by 73%. There was some variation among regions with respect to inpatient services, while all regions experienced increases in outpatient units of service.

Expenditures for Services

Since FY 1990-91, total expenditures for all services have increased 72% from $1.2 billion to over $2 billion in FY 1999-00. In addition to inflation, total expenditures for service have been affected by increased service usage and service intensity in the Medi-Cal population, but also by other factors which will be discussed later. Tables 8 and 9 show the increases and percent change by age for each of the four data points over the last ten years, for both the Medi-Cal and the indigent populations.

Table 8
Medi-Cal Expenditures[a/]

Statewide	Medi-Cal Expenditures				Ave. Annual Percent Change		
	1990-91	1993-94	1996-97	1999-2000	1991 to 1994	1994 to 1997	1997 to 2000
All Ages	272,814,386	424,863,466	716,193,297	1,018,509,162	15.9%	19.0%	12.5%
Ages 0 to 17	60,209,460	78,226,889	228,421,198	416,138,281	9.1%	42.9%	22.1%
All 18 and over	212,604,926	346,636,562	487,772,096	602,370,881	17.7%	12.1%	7.3%

a/ Excludes Medi-Cal Administrative Activities (MAA).

Table 9
Non-Medi-Cal Expenditures[a/]

Statewide	Non-Medi-Cal Expenditures				Ave. Annual Percent Change		
	1990-91	1993-94	1996-97	1999-2000	1991 to 1994	1994 to 1997	1997 to 2000
All Ages	846,258,709	657,419,884	707,076,759	993,569,289	-8.1	2.5%	12.0%
Ages 0 to 17	133,916,301	125,204,401	102,622,994	177,116,480	-2.2%	-6.4%	20.0%
All 18 and over	712,342,411	532,463,455	610,251,954	817,238,748	-9.2	4.7%	10.2%

a/ Excludes outreach services.

The trend of decreasing inpatient services and increasing outpatient services is also mirrored in the expenditures for these two service modes. As shown in Table 10, inpatient expenditures increased about 18%, while outpatient expenditures increased by 116%. This represents a significant shift in the percentage of funds spent on these services since realignment from 40% inpatient and 60% outpatient in FY 1990-91 to 27% inpatient and 73% outpatient in FY 1999-00.

Table 10
Comparison of Inpatient and Outpatient Expenditures[a/]

Region	Fiscal Year			
	1990-91	1993-94	1996-97	1999-2000
Inpatient				
Bay Area	122,350,331	123,743,873	129,743,207	151,102,839
Central	36,499,537	32,342,500	46,867,876	49,035,568
Los Angeles	180,409,967	156,843,491	184,146,832	192,678,831
Southern	93,033,389	86,582,249	92,331,151	122,003,320
Superior	13,372,818	9,003,895	9,470,085	12,107,899
Total-Inpatient	445,666,042	408,516,008	462,559,151	526,928,456
Outpatient				
Bay Area	225,088,447	214,254,911	329,488,557	490,367,848
Central	79,956,501	80,556,336	121,631,579	214,852,426
Los Angeles	176,138,906	173,509,788	255,595,732	317,008,247
Southern	173,796,706	177,944,139	219,144,789	378,348,156
Superior	18,426,493	27,038,366	32,907,709	53,937,489
Total-Outpatient	673,407,053	673,303,540	958,768,366	1,454,514,166

a/ Excludes outreach services and Medi-Cal Administrative Activities (MAA).

County mental health programs also report an increase in intensity of services to clients, which should be reflected in increasing service expenditures per client. Because of reporting problems and the inability of existing databases to "unduplicate" total clients across them, we do not have reliable data on per-client expenditures for all clients and all services during this time period.

Table 11, below, shows the comparison of realignment growth, increases in clients served, and combined medical inflation and client changes. Overall, percentage growth in medical inflation and client growth combined has been significantly greater than the growth in realignment. (See below subsection entitled "Overall Mental Health Realignment Funding," which follows Table 15, for a detailed description of the manner in which the medical inflation factor was computed.)

Table 11
Comparison of Realignment, Clients, and Medical Inflation

Region	Average Annual Percent Change 1990-91 to 1999-2000		
	Realignment Growth[a/]	Total Clients	Adjusted for Clients and Medical Inflation[b/]
Bay Area	2.4%	2.2%	6.7%
Central	3.8%	4.5%	9.1%
Los Angeles	2.3%	3.4%	7.9%
Southern	4.4%	7.8%	12.5%
Superior	2.5%	5.4%	10.0%
Total	3.1%	4.7%	9.3%

[a/] Compares expenditures on realigned mental health programs from fiscal year 1990-91 to the fiscal year 1999-2000 realignment allocations.

[b/] The medical inflation rate used (4.4%) represents the blended rate of the Home Health Market Basket Index and the Medical component of the CPI. The percentage change shown is the Realignment growth that would have been expected, if fully adjusted to account for the impact of client growth and medical inflation combined.

For most counties, the major changes that have occurred in the service delivery system since the enactment of realignment are the:

- large increase in the Medi-Cal client population, particularly among youth,
- change in service modes from inpatient to outpatient services,
- increase in the volume (units) of services being provided to clients.

As will be seen later in this report, changes due to realignment and changes in Medi-Cal funding have played a large role in these trends. In addition, counties and other stakeholders report that there is increasing demand for services and clients presenting with more severe disabilities. The data shows that units of service are increasing at a greater rate than the increase in number of clients.

With respect to expenditures, an analysis of county mental health program expenditures since realignment reveals small increases in inpatient expenditures, but significant increases in total expenditures. This may be due to in part to Medi-Cal consolidation, which allowed counties to renegotiate inpatient bed rates, and gave them the flexibility of creating and using less costly and less restrictive community-based services as an alternative to inpatient hospitalization. Other factors may include the availability of Adult System of Care funding, new and better medications, and service practices that assist clients in remaining in the community. The large increases in youth expenditures reflect the availability of funds--Children's System of Care funding and the implementation of EPSDT in 1995, which not only broadened eligibility criteria, but also created a fully funded service program for full scope Medi-Cal eligible youth under age twenty-one.

Revenues

Medi-Cal

As noted previously, Medi-Cal is a jointly funded state/local and federal program. The federal financial participation (FFP) has fluctuated between 50% and 52% during this time period.[5] Realignment replaced the state funds that were previously used as Medi-Cal match with sales tax and vehicle license fees. The state provides a fixed amount of funds for the consolidated mental health services and additional funds for EPSDT. Counties now contract with the DMH and assume all responsibility for the state match for Medi-Cal services, except for expanded EPSDT services.

Implementation of the Rehabilitation Option in 1993 allowed counties to increase FFP revenues significantly. Two additional changes to the Medi-Cal program have occurred since inception of realignment in FY 1991-92 that have resulted in counties receiving additional SGF funds which are used as Medi-Cal match. These changes are the Medi-Cal specialty mental health services consolidation discussed earlier and expansion of EPSDT services including the new Therapeutic Behavioral Services Medi-Cal benefit.

Under consolidation, SGF are appropriated each year to DMH based upon the estimated amount DHS would have incurred for psychiatric inpatient hospital services and psychiatrist and psychologist services absent consolidation. In general, each MHP receives, at a minimum, SGF equal to the amount spent in their county prior to consolidation. The majority of future growth in these services due to changes in Medi-Cal beneficiaries and/or cost of living is allocated to MHPs based on weighted relative need, which reflects the percentage of total need a MHP requires to equal the statewide weighted average cost per Medi-Cal

[5] The calculation is based on the federal fiscal year (Oct. - Sept) and has fluctuated between 50% and 52% beginning in 1996-97. Prior to that it was 50%. Exact percentages are--Federal FY 96-97 50.23%, 97-98 51.23%, 98-99 51.55%, 99-00 51.67

beneficiary in FY 1993-94, weighted by Medi-Cal aid code group. Note that relative need in FY 1995-96, the first year under inpatient consolidation, was calculated separately for each aid code group and was not weighted. Weighted relative need has not been recalculated since inpatient consolidation began, and MHPs with an above weighted average cost per Medi-Cal beneficiary in FY 1993-94 have not received a growth increase in their SGF allocation since FY 1995-96. However, MHPs have received increases in their overall allocations due to professional services consolidation, provider rate increases and other minor program changes. This SGF allocation is available to be used as Medi-Cal match by MHPs prior to using realignment funds.

A lawsuit in 1995 resulted in the expansion of Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who need specialty mental health services to correct or ameliorate mental illnesses, whether or not such services are covered under the Medicaid State Plan. As a result of the settlement, the state agreed to provide SGF as the match for these expanded specialty mental health services. These services qualify under the EPSDT Medi-Cal benefit and are commonly referred to as EPSDT services. DMH developed an interagency agreement with DHS through which county mental health plans are reimbursed the entire non-federal share of cost for all EPSDT-eligible services in excess of the expenditures made by each county for such services during FY 1994-95. When outpatient specialty mental health services consolidation was implemented, the baseline also increased by the proportion of that allocation that had historically been used for that population.

Another lawsuit, filed in 1998, recently resulted in the approval of a new EPSDT supplemental specialty mental health service for the Medi-Cal program. This new benefit is called Therapeutic Behavioral Services (TBS). Since these services were not included in the original realigned services, new SGF are provided to MHPs as match for these services

The DMH web site (see Appendix D.10 for more information) shows the FFP and required match for each county for Medi-Cal mental health services provided by MHPs. FFP in FYs 1996-97 and 1999-00 includes both the SD/MC program and inpatient consolidation. Appendix D.10 also shows the State General Fund allocations for managed care, EPSDT, and TBS. FY 1999-00 allocations for EPSDT and TBS were estimated based upon the most recently available cost report and claims information. The final settlement amounts could change pending review of the cost reports. Finally, Appendix D.10 shows the amount of realignment used as match for FFP, and the percent this reflects of total realignment funding.

Table 12, below, shows the percent of realignment by region required to match FFP, using the assumption that SGF managed care allocations, EPSDT, and TBS settlements are the first dollars used for match. Statewide, the percent of realignment funds required as Medi-Cal match has increased slightly since FY 1990-91. However, there are significant differences among the counties (see Appendix D.10), with at least 15 counties having to use a higher percent of realignment every year to cover Medi-Cal match requirements. These

differences are due to several factors—the amount of each county's original managed care allocation, how much Medi-Cal growth they receive each year, and how much of their Medi-Cal growth has been in EPSDT and TBS, which are both matched by SGF, rather than realignment dollars.

The statewide average is about 26 percent, but there are several counties that use more than half of their realignment as Medi-Cal match, leaving fewer funds for non-Medi-Cal clients and services.

Table 12

Percent of Realignment Needed as Match to FFP

	Fiscal Year			
Region	**1990-91**	**1993-94**	**1996-97**	**1999-2000**
Bay Area	21%	42%	45%	44%
Central	19%	28%	17%	16%
Southern	18%	28%	22%	23%
Superior	16%	31%	30%	35%
Los Angeles	12%	19%	16%	16%
Statewide	17%	29%	26%	26%

In conclusion, Medi-Cal funding has had a "mixed" impact on mental health services financing since realignment.

- Implementation of the Rehabilitation Option allowed counties to claim federal Medi-Cal dollars for some services that previously were funded 100% out of realignment funds, thus they were able to increase access and expand services. At the same time, the matching funds for these expanded services come out of realignment dollars.

- EPSDT and TBS also allowed counties to increase FFP, and additional SGFs are available as match, thus these programs represent increased funding which does not have to depend on realignment funding.

SGF managed care funding has kept up with population and medical inflation changes from a statewide perspective, but the growth in managed care funds for 18 individual counties has not kept pace because of the way these funds are allocated. Allocations are based in part upon an "equity" type formula. Eight counties are not receiving allocations based on equity and must therefore use more of their realignment funds. In addition, start-up costs for new programs, increased cost of administration, and alternative services needed to manage care are not taken into account in determining SGF managed care allocations, thus these costs also are covered by realignment or other funds.

Realignment

In order to assess the current status of realignment funding for mental health services, it is necessary to look at several factors, including overall county, regional and statewide realignment allocation data, realignment growth figures, transfers between realignment accounts at the local level and mental health realignment allocations in FY 2000-01. This next section provides an analysis of this data over the nine years since realignment was implemented. Yearly data and data for each county are included in Appendix D as noted; summary statewide and regional data are included in the body of this report.

This analysis includes both sales tax and vehicle license fee revenues. Under realignment, mental health programs also receive $14 million from vehicle license fee collections. These fees are to offset part of the $40 million in Tobacco Tax revenues that were removed from mental health in FY 1992-93. The DMH web site (see Appendix D.7 for more information) shows vehicle license fee collections. These funds are distributed to counties based on how the Tobacco Tax revenues were lost. These revenues are not included in the analyses below because the county amounts do not vary annually from the $14 million allocation.

Comparison Between Mental Health, Social Services, and Health Programs

Appendix D.2 shows the Realignment Annual Base History for mental health, social services, and health for FYs 1991-92 through 2000-01. Table 13, below, compares FY 1991-92 allocations with FY 2000-01 allocations for each of the programs.

Table 13

Comparison of Realignment Funding
FY 1991-92 and FY 2000-01

Program	Realignment Allocation		Percent of Total Realignment	
	FY 1991-92	FY 2000-01	FY 1991-92	FY 2000-01
Mental Health	$668,009,311	$1,078,152,616	34.3%	30.5%
Social Services	450,457,460	1,045,972,668	23.1%	29.6%
Health	830,044,166	1,412,589,275	42.6%	39.9%
Total	$1,948,510,937	$3,536,714,559	100.0%	100.0%

As shown in Table 13, the share of realignment allocated to mental health and health programs has decreased from FY 1991-92 to FY 2000-01, while social services has increased the share of realignment. This is further exemplified in Table 14, below, which shows the distribution of growth from inception of realignment through FY 2000-01 by program, excluding allocations used to restore programs to the FY 1990-91 base amounts.

Table 14

**Distribution of Realignment Growth*
FY 1991-92 through FY 2000-01**

Fund Source	**Mental Health**	**Social Services**	**Health**	**Total**
Sales Tax	$132,118,136	$530,377,996	$191,408,284	$853,904,416
Vehicle License Fee	192,080,632	25,970,015	280,269,066	498,319,713
Total	$324,198,768	$556,348,011	$471,677,350	$1,352,224,129
Percent of Growth	24.0%	41.1%	34.9%	100.0%

* Excluding base restoration allocations

Table 14 shows that the majority of realignment growth (over 41 percent) went to the social services program, largely due to increases in caseload expenditures. The health program had the second highest growth due to the percent of vehicle license fee growth allocated to health program sub accounts. Mental health had the least amount of growth funds, approximately 60 percent of what the social services program received.

Transfers Between Mental Health, Social Services, and Health Programs

The realignment legislation provided additional local flexibility through the ability of local governments to transfer funds between the three realigned programs (mental health, social services, and health) to reflect the local needs and priorities of the realigned programs. The transfer amount may not exceed ten percent of the amount deposited in the account from which the funds are to be reallocated for that fiscal year. Any funds transferred to a different program still must be spent on realigned programs.

Table 15, following, summarizes the total transfers between programs for the seven-year period of FY 1993-94 through FY 1999-00. All of the FY 2000-01 transfer amounts had not been reported to the State Controller's Office as of the time of this report and were not included. Table 15 shows transfer amounts by region. Appendix D.6 shows the transfer amounts by county and by fiscal year that comprise Table 15.

Table 15

Seven-Year Aggregate Realignment Transfers
FY 1993-94 through FY 1999-2000

Region	Mental Health	Social Services	Health
Bay Area	$31,463,864	$3,891,947	($35,355,811)
Central	(48,929,517)	50,218,443	(1,288,926)
Southern	(21,192,611)	7,086,276	14,106,335
Superior Counties	(3,492,007)	6,629,380	(3,137,373)
Los Angeles	(32,300,000)	81,900,000	(49,600,000)
Total	($74,450,271)	$149,726,046	($75,275,775)

Table 15 shows that, overall, realignment funds allocated to mental health and health programs were transferred to the social services account to pay for social services programs. About $75 million was transferred both from mental health and health to provide $150 million in additional social services funding. However, in aggregate, these transfers are relatively minor and represent approximately one percent of the overall mental health realignment allocations during this seven-year period.

Yet the transfers vary significantly by region and have a greater impact on some counties than on others, as shown by Appendix D.6. The increase in mental health funding in the Bay Area is primarily due to transfers in Santa Clara County, where over $32 million has been transferred into the mental health program from the health program. The large transfer out of mental health in the Central region is due to large transfers in Fresno, Sacramento, and San Joaquin counties. San Bernardino, Ventura, and Kern counties account for the majority of the transfers out of mental health in the Southern region, while Butte accounts for the majority of transfers out of the Superior County region, all of which occurred in the last three years.

Overall Mental Health Realignment Funding

Appendix D.2 shows actual realignment funding by county for FYs 1991-92 through 2000-01. Due to a decrease in sales tax and vehicle license fee revenue in FY 1991-92, realigned services were not funded initially at the FY 1990-91 levels. For mental health services, counties received $668 million, about $82 million less than the actual expenditures for realigned services in FY 1990-91. Funding levels finally met or exceeded the initial FY 1990-91 amounts in FY 1994-95 (the fourth year of realignment).

As shown in Tables in Appendix D.2, mental health realignment funding has increased from $668 million in FY 1991-92 to almost $1.1 billion in FY 2000-01, or an average of about 5.5 percent per year. However, when compared to the FY 1990-91 spending level of realigned services, realignment spending has increased about 3.7 percent per year since FY 1990-91. This level of growth is less than the growth in population and medical inflation that occurred during that time period, as indicated in Appendix D.5. Changes in population were compiled from the California Department of Finance Demographic Research Unit, *County Population Projections with Race/Ethnic Detail, 1990-2040*, published in December 1998. These figures are shown in Appendix D.1b. The medical inflation factor represents a blend of the Home Health Agency Market Basket Index (HHAMB) as published by the federal Center for Medicaid and Medicare Studies (CMS), Office of the Actuary in June 1999, and the Medical Component of the Consumer Price Index (CPI) from the Department of Mental Health. In consultation with CMS, DMH selected these two indices and blended them based on the percentage of outpatient (79 percent) and inpatient (21 percent) Short-Doyle/Medi-Cal claims in FY1998-99. These two indices are used to establish the maximum rates allowable under the Short-Doyle/Medi-Cal program and, because of this, are assumed to be reflective of the expenditure increases in mental health services. Appendix D.5 shows the HHAMB, the Medical component of the CPI, and the blended rate.

Table 16, below, compares actual mental health realignment allocations in FY 2000-01 to what mental health realignment allocations would have been had they kept up with changes in medical inflation and population (as calculated in Appendix D.5) since inception of realignment in FY 1991-92 (not compared to the higher spending levels in FY 1990-91). The data is shown by region.

Table 16
Comparison of Actual to Estimated Mental Health Realignment Allocations
Fiscal Year 2000-01

Region	Actual	Estimated	Shortfall*
Bay Area	$269,745,072	$289,979,863	($20,564,971)
Central	159,181,214	151,391,584	(4,833,885)
Southern	293,332,836	265,710,521	(1,811,651)
Superior Counties	36,771,900	38,461,732	(2,018,199)
Los Angeles	319,121,581	330,628,603	(11,507,022)
Total	$1,078,152,603	$1,076,172,303	($40,735,728)

*Shortfall does not equal the difference between columns because surpluses in one county cannot be used to cover shortfalls in another county.

Table 16 shows that the realignment funding for mental health in FY 2000-01 was $40.7 million less would have been required to keep pace with medical

inflation and population increases since the inception of realignment in FY 1991-92, and that the impact varies by region. Overall, 38 counties were apportioned less realignment funding for mental health services in FY 2000-01 than in FY 1991-92 when adjusted for population and medical inflation changes.

The above analysis does not differentiate between equity growth and general growth, nor does it consider the decrease in funding that occurred in FY 1991-92 as a result of lower sales tax and vehicle license fees. If equity growth is excluded, allocations under mental health realignment have lagged increases in population and medical inflation. Table 17, below, compares actual mental health realignment allocations in FY 2000-01 (excluding equity growth for all fiscal years) to what mental health realignment allocations would have been had they kept pace with medical inflation and population since the inception of realignment in FY 1991-92.

Table 17
Comparison of Actual to Estimated Mental Health Realignment Allocations
(Excluding Equity Growth Allocations)
FY 2000-01

Region	Actual	Estimated	Shortfall*
Bay Area	$264,995,742	$289,979,863	($24,984,121)
Central	135,334,857	151,391,584	(16,116,421)
Southern	239,549,929	265,710,521	(26,206,841)
Superior Counties	35,446,880	38,461,732	(3,117,503)
Los Angeles	306,317,419	330,628,603	(24,311,184)
Total	$981,644,827	$1,076,172,303	($94,736,070)

*Shortfall does not equal the difference between columns because surpluses in one county cannot be used to cover shortfalls in another county.

Table 17 shows that the realignment funding for mental health in FY 2000-01 was $94.7 million less than the amount needed to bring counties up to the same level of realignment allocations as in FY 1991-92 after adjusting for medical inflation and population changes, and excluding realignment growth allocations for equity. The Southern region shows larger shortfalls because San Diego, Riverside, and Orange counties have received significant equity allocations but not general growth allocations. The same holds true for the counties of Sacramento, San Joaquin, and Fresno in the Central region. Based on the above methodology, six cities and counties of the 59 city and county mental health programs' mental health realignment allocations have kept pace with medical inflation and population since FY 1991-92.

Summary of Data Analysis

AB 328 directed the State Department of Mental Health to report to the Legislature about three areas of mental health financing and service delivery since Realignment – revenues, services and expenditures. A summary of the findings based on the data analysis is presented below.

Services

- The emphasis on a clear mission and defined target populations under realignment has allowed counties to develop comprehensive community-based systems of care for individuals with severe mental illness and serious emotional disorders. Increased county flexibility has further allowed counties to institute best practices, which appear to be more effective in the recovery process for individuals with severe mental illness and serious emotional disturbance.

- As a result of the changes in Medi-Cal and realignment funding over the past 10 years counties have been able to reduce inpatient services and use cost savings to increase access and create more appropriate and less restrictive community treatment services.

- Usage of services for individuals with severe mental illness and serious emotional disorders has been increasing. This is reflected both in increasing numbers of clients served and the increasing intensity of services provided per client.

- Units of service for indigent clients are decreasing in relation to Medi-Cal clients.

- Some counties are reporting that they may reduce the numbers of people they are serving, or decrease the amount of services individuals are receiving, or both. When funding reductions are necessary, the programs most likely to be cut are those that do not directly affect the most costly services (i.e., inpatient services).

- All regions of the state experienced an increase in the proportion of Medi-Cal beneficiaries receiving mental health services.

- The number of clients served increased at a more rapid rate than the potential service population.

- The growth in services for children and youth was much greater than for adults.

- There has been a shift from more costly and restrictive inpatient services to less costly and restrictive outpatient services.

Expenditures

- Total mental health expenditures have increased 72% since the enactment of realignment.

- Increased expenditures are due to many factors, which may include medical inflation (as calculated by DMH in consultation with CMS), increased service usage, increased acuity of clients, and other factors such as housing and staffing costs.

- The percentage increase in medical inflation and client growth combined has been greater than the increase in realignment revenues. However, the problem has been ameliorated to some extent by increased funding in other areas.

Revenues

- Under the current funding structure, funds apportioned to the counties under realignment have not kept pace with FY 1991-92 levels when population changes and medical inflation are taken into account.

- Since Realignment, counties have been affected differentially, based on their "equity" status, demographics and economic conditions. The counties that are "at equity" have experienced the smallest increases in available funding, as they receive minimal sales tax growth, they receive no equity growth, and their Medi-Cal managed care allocations have frequently been lower than other counties. Because the equity sub-account has now reached its cap, all counties will receive slightly more growth. Under-equity counties will, in some cases, receive significantly less funding than they have historically received since implementation of Realignment, as growth is distributed to all counties under the general growth formulas.

- The growth in federal Medi-Cal revenues under the Rehabilitation Option and consolidation has helped to offset realignment shortfalls. However, this growth seems to be leveling off in the area of services to adults, where counties use realignment funds for match. Also, many counties use an increasing proportion of their realignment dollars for Medi-Cal match, and have decreased the amount of funds expended for indigent clients.

- Additional SGF has been provided in the form of new initiatives that have funded services to new target populations and expanded services rather than expanding base funding.